

#### Americans with Disabilities Act

# Employee Self-Identification and Request For Accommodation

Request For Accommodation

This form must be completed and submitted to the Office for Institutional Equity when an employee wishes to self-identify and make a request for accommodation due to a documented disability. To be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA), the employee must be qualified to perform the essential functions of his/her position with or without an accommodation and have a qualifying disability that limits a major life function.

Employee name:	Employee home phone:
Monigue Small (Drew)	804 -458-5222
Employee address:	Cell number:
4123 Robert E LEE Drive	804-498-2732
Hupewell , VA 23860	Work number: 971-0450
	Supervisor phone number:
Brandon Dingess	864 513-4771
Department:  Packing Transpiration  1. Please describe which major life activity your impa	Date: 4-24-15
1. Please describe which major life activity your impa	rment limits. (For example: caring for oneself,
performing manual tasks, walking, seeing, hearing, sit	ting, speaking, breathing, learning, remembering,
concentrating, etc.)	
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Employee address:  123 Robert Elee Drive Re-1-490-2732  Work number:  You G71-0450  Supervisor Phone number:  Supervisor P	Employee address:  123 Robert & Let Drive   Se-1-490-2734   Work number: Supervisor:  Brandon Dougest   Supervisor phone number: Se 4 5/3 4/77!  Department: Por king   Trans performed performing manual tasks, walking, seeing, hearing, sitting, speaking, breathing, learning, remembering, concentrating, etc.)  2. Describe how your condition limits your ability to perform the essential functions of your job. Using your Employee Work Profile or faculty work plan (job description), identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance. (Your Employee	Employee name:	Employee home phone:
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Work number:  Supervisor phone number:  Supe	Work number:  Supervisor  Brandon Dingest  Department:  Parking Transpartorie  Date: 4.24-15  1. Please destribe which major life activity your impairment limits. (For example: caring for oneself, performing manual tasks, walking, seeing, hearing, sitting, speaking, breathing, learning, remembering, concentrating, etc.)  2. Describe how your condition limits your ability to perform the essential functions of your job. Using your Employee Work Profile or faculty work plan (job description), identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance. (Your Employee Work Profile can be obtained through your immediate supervisor or through the Division of Human resources. Faculty work plans can be obtained through department chairs or directors.)  3. Describe in detail the accommodation(s) you are requesting:  4. Please add any additional information you feel may be relevant to your request:	Employee address:	Cell number;
Supervisor phone number:  Brandon Dingess Supervisor phone number:  Brandon Dingess Supervisor phone number:  Brandon Dingess Supervisor phone number:  Bear King Train partone Supervisor phone number:  Branking Train partone Supervisor phone	Supervisor  Supervisor  Brandon  Department:  Par   Transparation  Detect  Person part of the second part of	1123 Robert & LEE Drive	
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### Physician's Certification for

### Employee Accommodation

We have received notice from you and/or your doctor indicating that you have a condition that requires an accommodation in the workplace. In order to process this request, additional information is needed from the treating physician. Please ask your physician to review your Employee Work Profile (job description) or faculty work plan (job description) with you and complete this certification and return it to the Office for Institutional Equity as soon as possible. This information must be received in order to process your request. Position \_ **Employee Name** 1). Describe the (a) nature, (b) severity, and (c) duration of the employee's impairment. 2). Describe the major life activity or activities the impairment limits (i.e. walking, breathing, seeing, etc.) 3). Describe how this condition limits the employee's ability to perform the essential functions of the job. Using the Employee Work Profile (job description) or faculty work plan (job description), identify the essential functions affected and how the medical condition impairs the employee in each instance.

4).	Describe the accommodation requested and why the requested reasonable accommodation is needed.
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	- ROGENING PULLINA
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	Preses TENSIERIA Heating (Co)
5).	Are there any alternative accommodations that may also be feasible (not listed in #4).
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Physician's Signatu	Date
Physician's Printed	Name Name Control of the Control of
Address	Stony Port Phily
Richian	CVIC, V A. DESCESS
Telephone Number	537-74163

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Signature of Health Care Provider	Date Date	.41×4112	

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616, 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

#### Position's Physical/Cognitive Requirements:

<b>Physical</b>	<b>Demands</b>	and Activities:
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M	Heavy lifting	(>50 lbs.)	Every I how
N/A	Pushing/pulling	E Walking	* itoth 41-1DAY LEI
E	Standing	N/A Climbing	the week
E	Sitting	N/A Reaching	8 to prophing at fu
М	Repetitive motion	N/A Bending	
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**Topic: Accommodation Request for Monique Drew** 

To: Monique Drew, Charles B Dingess

Date: May 26, 2015

Ms. Drew has filed all the relevant paperwork to receive accommodations via the Americans with Disabilities Act. Accommodations are requested as follows:

- Ms. Drew has restricted mobility, she cannot walk long distances.
- Ms. Drew needs to take a 10-15 minute break every two hours.
- Ms. Drew cannot engage in activities that involve pushing or pulling or repetitive motions.

**Gmail works better with Chrome** 

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COMPOSE

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More

Search people Ashley C Rogers chesterbw jas.pegram ladrew larrydrew911

**Paperwork** 

to me

inbox x

People (2)

· Paula L McMahon ADA COORDINATOR

Ms. Drew

Paula L McMahon <mcmahonpl2@vcu edu>

I was out at a meeting last week. I am in receipt of some paperwaitnfartyous and wanted to know if we could meet or talk over the plause to discuss this further. Please let me know what would work for you.

Sincerely

Paula

Paula McMahon MSc. CRC. ADACT Americans with Disabilities Act (ADA) Coordinator Office for Institutional Equity 817 South Cathedral Place Room 1006 P.O. Box 843022 Virginia Commonwealth University

Phone: 804-828-8947 Fax: 804-828-7201 Voice/TTY: 804-828-1420

Richmond, VA - 23284-3022

Website: www.equity.vcu.edu



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